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ASSESSMENT PROCEDURES

Validity, reliability and minimal detectable change of the balance evaluation systems test (BESTest), mini-BESTest and brief-BESTest in patients with end-stage renal disease

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ABSTRACT

Purpose: This study determined the validity, test–retest reliability and minimal detectable change of the balance evaluation systems test (BESTest), mini-balance evaluation systems test (Mini-BESTest) and brief-balance evaluation systems test (Brief-BESTest) in patients with end-stage renal disease.

Methods: A cross-sectional study with 74 patients with end-stage renal disease (male 66.2%; 63.9 ± 15.1 years old) was conducted. Participants were asked to report the number of falls during the previous 12 months and to complete the activity-specific balance confidence (ABC) scale. The BESTest was administered, and the Mini-BESTest and Brief-BESTest scores were computed based on the BESTest performance. Validity was assessed by correlating balance tests with each other and with the ABC scale. Test–retest relative reliability and agreement were explored with the intraclass correlation coefficient (ICC) equation (2,1) and the Bland and Altman method. Minimal detectable changes at the 95% confidence level were established.

Results: Balance test scores were significantly correlated with each other (spearman's correlation = 0.89–0.92) and with the ABC scale (spearman's correlation = 0.49–0.59). Balance tests presented high test–retest reliability (ICC = 0.84–0.94), with no evidence of bias. Minimal detectable change values were 10.8 (expressed as a percentage 13.5%), 5.3 (23.7%) and 5.6 (34%) points for the BESTest, Mini-BESTest and Brief-BESTest, respectively.

Conclusions: All tests are valid and reliable to assess balance in patients with end-stage renal disease. Nevertheless, based on the minimal detectable changes found, BESTest and Mini-BESTest may be the most recommended tests for this specific population.

KEYWORDS

Chronic kidney failure; dialysis; postural balance; risk assessment; reproducibility of results

► IMPLICATIONS FOR REHABILITATION

- Balance evaluation systems test (BESTest), mini-balance evaluation systems test (Mini-BESTest) and brief-balance evaluation systems test (Brief-BESTest) are reliable and valid in patients with end stage renal disease (ESRD).
- The minimal detectable changes of 10.8 for the BESTest, 5.3 for the Mini-BESTest and 5.6 for the Brief-BESTest can be used by clinicians to identify a true change in balance over time or in response to interventions.
- Based on the minimal detectable changes found, BESTest and Mini-BESTest may be the most recommended; and the selection of one of them may be based on time and equipment availability.

Introduction

Chronic kidney disease affects 11–13% of the population world- wide [1], being an important public health issue with high socio-economic burden. This long-term and progressive condition is associated with fatigue, muscle weakness and reduced physical activity [2,3]. As a result, patients with chronic kidney disease, and particularly with end stage renal disease (ESRD) may experience difficulties in performing activities of daily living that require balance control and be at high risk of falling [4].

Recent literature indicates that 17.2–47% of patients with ESRD fall at least once during a 3–12 month period [5,6]. Thus, valid, reliable and clinically feasible tests for comprehensive assessment of balance impairments are needed to screen balance impairments, inform the design and evaluate the impact of optimal interventions for fall reduction.

A number of balance tests have been described in the literature [7,8]. The balance evaluation systems test (BESTest) was developed to assess balance comprehensively. It assesses functioning of six balance control systems [9] and has been one of the most commonly used test in patients with chronic diseases, such as cancer [10], Parkinson's disease [11] and chronic obstructive pulmonary disease [12]. However, while the clinimetric properties of this test, such as validity, test–retest reliability and minimal detectable change, have been established in several specific populations [13–15], they have not yet been investigated in patients with ESRD.

Due to the time required to complete the BESTest (approximately 20–30 min) [14], shortened versions were developed, the Mini-BESTest [16] and the Brief-BESTest [14]. The Mini-BESTest includes important aspects of dynamic balance control, reflecting

balance challenges during activities of daily living (administration takes approximately 15 min) [16]. In contrast, the Brief BESTest contains items that assess all balance systems outlined by the original BESTest, requires less administration time (approximately 10 min) and less equipment, which can favor its clinical use [14]. These shortened versions have also gained interest to assess balance in patients with Parkinson's disease [17], multiple sclerosis [14], and balance disorders [18]. Nevertheless, to the authors' knowledge, neither the Mini-BESTest nor the Brief-BESTest have been applied, or their clinimetric properties studied, in patients with ESRD. Determining the clinimetric properties and associated measurement error of these tests is fundamental to decide whether they are appropriate to detect balance impairments in patients with ESRD [19] and can be used in the clinical management of these patients.

Therefore, the purpose of this study was to determine the validity, test–retest reliability and the minimal detectable change of the BESTest, Mini-BESTest and the Brief-BESTest in patients with ESRD.

Methods

Study design and ethics

A cross-sectional study was conducted from December 2013 to June 2014 in the central region of Portugal. Ethical approval was obtained from the Ethics Committee of the Research Unit of Health Sciences at the School of Nursing in Coimbra (P185-10/ 2013). This study is reported following the COnsensus-based Standards for the selection of health Measurement Instruments [19], the STrengthening the Reporting of OBservational studies in Epidemiology statement [20] and the guidelines for reliability and agreement studies [21].

Participants

Three renal dialysis centers participated and clinicians in each center identified eligible patients according to the following criteria: (i) had ESRD; (ii) were receiving adequate hemodialysis or peritoneal dialysis for at least three months ($Kt/V > 1.2$) and (iii) were aged 18 years or older. Patients were excluded if they (i) had an hospitalization within the past three months due to worsening of their health status; (ii) had comorbidities that interfered with independent ambulation (e.g., hip fracture, lower limb amputation); (iii) were taking medication that could cause dizziness or affect their balance (e.g., psychotropic medications); (iv) had severe respiratory (e.g., chronic obstructive pulmonary disease), neurological (e.g., Parkinson's disease, multiple sclerosis), musculoskeletal (e.g., severe osteoarthritis) or psychiatric (e.g., psychosis, schizophrenia) disorders, that could interfere with the measurements. After screening, patients were contacted by the clinician, who explained the purpose of the study and asked about their willingness to participate. When patients agreed to participate, an appointment with the researchers was scheduled at their dialysis center. Written informed consent was obtained prior to data collection.

Data collection procedures

Two research physiotherapists collected the data. Socio-demographic (age and gender), anthropometric (height, weight, body mass index) and clinical (self-reported comorbidities – e.g., hypertension and hyperlipidemia) data were first collected. Patients were then provided with a clear definition of falls (an event when you find yourself unintentionally on the ground, floor or lower level) [22] and required to report their history of falls using two standardized questions (1. “Have you had any falls in the last 12 months?” and, if yes, 2. “How many times did you fall down in the last 12 months?”) [23]. The self-reported activities-specific balance confidence (ABC) scale was used to assess balance confidence [24]. This scale quantifies an individual's perceived ability to maintain his/her balance under different circumstances, using a scale of 0% (no confidence) to 100% (total confidence) [25]. Finally, the BESTest was performed and participants were encouraged to rest, as needed.

For each item of the BESTest, the physiotherapist read the instructions to the participant and performed the task. Then, the participant performed the task with close supervision. For test–retest reliability, participants were reassessed by 1 of the 2 physiotherapists within five days after session 1. Effort was made to keep all factors associated with the testing sessions consistent, specifically the time of day, area in which the tests were performed and use of a walking aid (if needed). The Mini-BESTest and Brief-BESTest scores were computed based on the performance of the BESTest tasks. A custom designed worksheet was used by the physiotherapists to simultaneously record the BESTest and the Mini-BESTest item scores. Brief-BESTest scores were extracted from the relevant subset of BESTest items.

Balance tests

BESTest

The BESTest contains 36 items organized into six subsections: bio-mechanical constraints, stability limits and verticality, anticipatory postural adjustments, postural responses to external perturbations, sensory orientation during stance and stability in gait [9]. Each item is scored from 0 (severe balance impairment) to 3 (no balance impairment) and the maximum possible total score is 108 points. BESTest has high test–retest reliability (Intraclass Correlation Coefficient [ICC] = 0.87–0.92) in individuals with and without balance disorders, in patients with Parkinson's disease, in older cancer survivors and in patients with chronic obstructive pulmonary disease [9,10,13,15].

Mini-BESTes

The Mini-BESTest includes 14 items from sections of the BESTest related to anticipatory postural adjustments, reactive postural responses, sensory orientation and stability in gait [16]. Two of the 14 items are scored bilaterally. Each item is scored from 0 (severe balance impairment) to 2 (no balance impairment) and the maximum possible score is 28 points. Higher scores indicate better balance performance. High test–retest reliability (ICC = 0.88–0.97) have also been found in patients with balance

disorders, Parkinson's disease, chronic stroke, chronic obstructive pulmonary disease and also in older cancer survivors [10,11,15,18,26].

Brief-BESTest

The Brief-BESTest is a six-item balance test, which contains one item from each of the six subsections of the BESTest [14]. Two of the six items are scored bilaterally, resulting in an eight-item balance test. Each item is scored from 0 (severe balance impairment) to 3 (no balance impairment) and the maximum possible score is 24 points. Higher scores indicate better balance performance [14]. It has also showed high test-retest (ICC = 0.82–0.94) reliability in patients with chronic obstructive pulmonary disease [15], older cancer survivors [10] and older adults living in the community [27].

Statistical analysis

Descriptive statistics were used to describe the sample. A z-test was applied for normality test using skewness and kurtosis [28]. Patients with a history of falls were defined as those who reported at least one fall during the past year; patients without a history of falls were defined as those who reported no falls during the past year. Participants' characteristics were compared between (i) those with and without a history of falls and (ii) those included in the reliability analysis and the remaining sample, using independent *t*-tests for normally distributed data, Mann–Whitney *U*-tests for non-normally distributed and Chi-square tests for categorical data.

Reliability

Test-retest reliability was analyzed in a subsample of the first consecutive 31 participants. This sample size was determined according to the study from Bonnet [29], which has established that a minimum of 21 individuals were necessary to estimate an ICC of 0.9 with a 95% confidence interval width of 0.230 ($\alpha = 0.05$ and $k = 2$). As interventions with patients with chronic kidney disease at various stages have considerable dropouts [30], a 40% attrition rate was estimated, yielding a sample of 31 participants.

Test-retest reliability was computed using the scores from the same physiotherapist in sessions 1 and 2. For relative reliability, the ICC Equation (2,1) was used as it was intended to generalize the present results to a variety of raters [31]. ICC was interpreted as excellent (>0.75), moderate to good (0.4–0.75) or poor (<0.4) [32]. Agreement was explored with the Bland and Altman method and standard error of measurement (SEM). The Bland and Altman method was used for visual judgement of how well the measurements between sessions agreed [31].

The SEM indicates the extent to which a score varies on repeated measurements. It provides a value for measurement error in the same units as the measurement itself and thus, is easier to use in clinical practice [33]. It was calculated using Equation (1):

$$SEM = SD\sqrt{1 - ICC} \quad (1)$$

where SD is the standard deviation of the scores obtained from all individuals and ICC is the test-retest reliability coefficient.

Minimal detectable change

The MDC at the 95% level of confidence (MDC₉₅), is also reported in the same units as the measurement itself and represents the smallest change that can be interpreted as a real difference. It was calculated as follows Equation (2):

$$MDC_{95} = SEM \times 1.96 \times \sqrt{2} \quad (2)$$

The MDC was also expressed as a percentage (MDC%), defined as Equation (3):

$$MDC\% = (MDC_{95}/\text{mean}) \times 100 \quad (3)$$

where mean is the mean of the scores obtained in the two testing sessions. The MDC% is independent of the units of measurement and facilitates the comparison of the random measurement error among different measures [34]. A MDC% below 30% is considered acceptable [35].

Validity

Spearman's correlation coefficient (*rho*) was used to examine the relationship among balance tests (concurrent validity) and between each balance test and the ABC scale (convergent validity).

All statistical analyses were performed using IBM SPSS Statistics version 20.0 (IBM Corporation, Armonk, NY) and plots created using GraphPad Prism version 5.01 (GraphPad Software, Inc., La Jolla, CA). The level of significance was set at 0.05.

Results

Participants

A total of 131 patients were screened and 82 were eligible. Two participants refused to participate and 6 did not complete the assessment. Therefore, 74 participants were included. Participants had a mean age of 63.9 ± 15.1 years old and were mainly male ($n = 49$; 66.2%). Twenty-eight (37.8%) participants had history of falls. Twelve participants used walking aids, 11 used a cane and one used a walker. Participants' characteristics and balance scores are presented in Table 1. All balance tests were able to significantly differentiate between participants among age ranges (Table 2).

Validity

All balance tests were strongly correlated with each other, with ρ ranging from 0.89 to 0.92 ($p < 0.001$). The ABC scale was significantly correlated with the BESTest ($\rho = 0.59$), Mini-BESTest ($\rho = 0.49$) and the Brief-BESTest ($\rho = 0.5$) (Figure 1).

Table 1. Participants' characteristics ($n = 74$).

| Characteristics | Total ($n = 74$) | Without history of falls ($n = 46$) | With history of falls ($n = 28$) | p value |
|--|--------------------|---------------------------------------|------------------------------------|-----------|
| Age (years) | 63.9 (15.1) | 61 (15.8) | 68.8 (12.8) | 0.029* |
| Male, n (%) | 49 (66.2) | 32 (69.6) | 17 (60.7) | 0.298 |
| BMI (kg/m^2) | 25.1 (4.3) | 25.8 (4.7) | 24.1 (3.2) | 0.068 |
| Walking aid, n (%) | 12 (16.2) | 5 (10.9) | 7 (25.0) | 0.765 |
| Comorbidities, M [IQR] | 1 [0, 2] | 1 [0, 2] | 2 [0, 2.75] | 0.403 |
| Activities-specific balance confidence scale | 64 (26.2) | 69.5 (24.8) | 55.4 (26.6) | 0.034* |
| BESTest | 77.9 (17.3) | 82 (15.6) | 71.4 (18.1) | 0.013* |
| Mini-BESTest | 21.7 (6) | 22.8 (5.4) | 20 (6.5) | 0.061 |
| Brief-BESTest | 14.9 (6.4) | 16.6 (6.3) | 12.1 (5.8) | 0.003* |

Values shows mean (SD) unless otherwise indicated.

BESTest: balance evaluation systems test; BMI: body mass index; IQR: interquartile range; M: median.

* $p < 0.05$.

Test-retest reliability

The characteristics of participants included in the reliability analysis ($n = 31$) were not significantly different from remaining participants. Table 3 presents the relative test-retest reliability and the agreement of the BESTest, Mini-BESTest and the Brief-BESTest. Excellent test-retest reliability was observed. Good test-retest agreement was verified for all balance tests, with mean differences close to zero (Table 3 and Figure 2).

Minimal detectable change

The MDC₉₅ was 10.8 (SEM=3.9; MDC%=13.5%), 5.3 (SEM = 1.9; MDC% = 23.7%) and 5.6 (SEM = 2; MDC% = 34%) for the BESTest, Mini-BESTest and the Brief-BESTest, respectively.

Table 2. Balance tests scores per age ranges ($n = 74$).

| Characteristics | 30–49 y ($n = 16$) | 50–69 y ($n = 27$) | >70 y ($n = 31$) | p value |
|-----------------|----------------------|----------------------|--------------------|-----------|
| BESTest | 93.5 (6.6) | 76.1 (18.8) | 70.8 (14.5) | <0.001 |
| Mini-BESTest | 26.2 (1.8) | 21.4 (6.4) | 19.6 (5.9) | 0.001 |
| Brief-BESTest | 21.5 (2.8) | 14.7 (5.6) | 11.5 (5.8) | <0.001 |

Values show mean (SD).

BESTest: balance evaluation systems test.

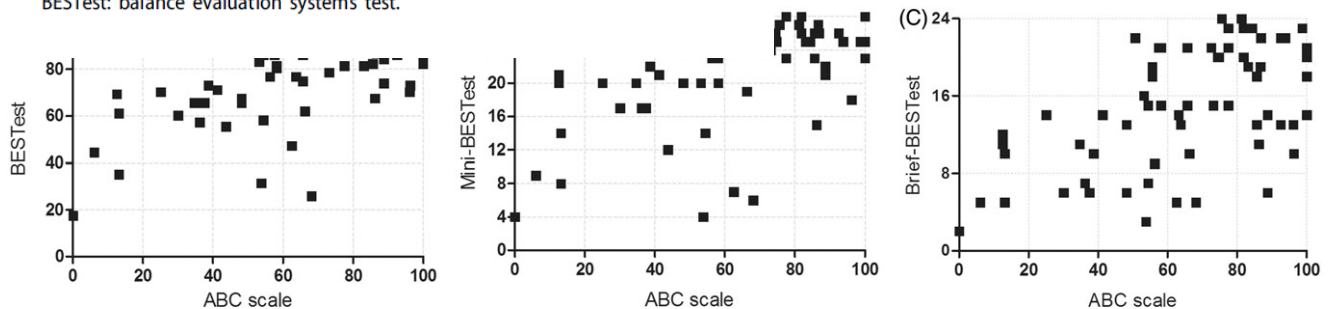


Figure 1. Scatterplots showing the relationship between the activities-specific balance confidence (ABC) scale and (A) the balance evaluation systems test (BESTest), (B) the Mini-BESTest and (C) the Brief-BESTest ($n = 74$).

Table 3. Test–retest reliability of the balance evaluation systems test (BESTest), Mini-BESTest and the Brief-BESTest ($n = 31$).

| Balance test | Relative reliability | | Agreement | |
|---------------|----------------------|-----------|----------------------|------------|
| | ICC _{2,1} | 95% CI | Mean difference (SD) | 95% LA |
| BESTest | 0.94 | 0.87→0.97 | −0.7 (5.9) | −12.3→10.8 |
| Mini-BESTest | 0.84 | 0.70→0.92 | −0.4 (2.9) | −6→5.3 |
| Brief-BESTest | 0.84 | 0.69→0.92 | 0.2 (3) | −5.7→6.1 |

The ICC equations used were the ICC_{2,1}.

95% CI: 95% confidence intervals; ICC: intraclass correlation coefficient; SD: standard deviation; 95% LA: 95% limits of agreement.

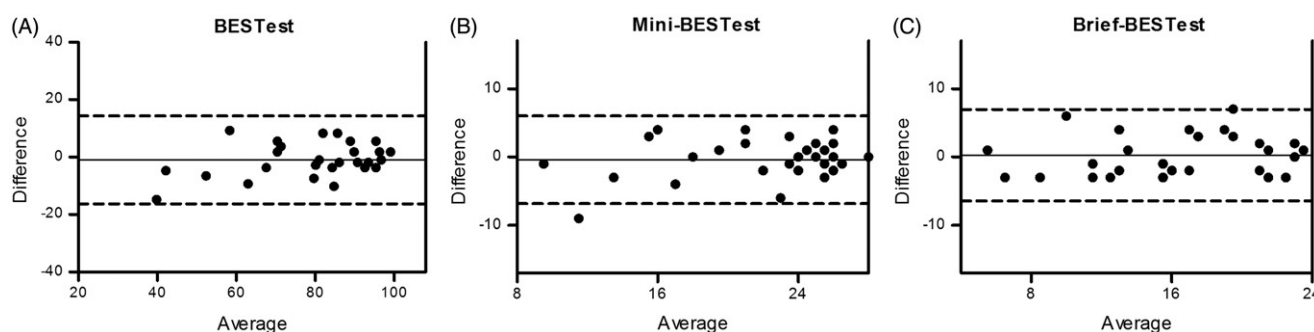


Figure 2. Bland and Altman plots of the (A) balance evaluation systems test (BESTest), (B) Mini-BESTest and (C) Brief-BESTest between two sessions ($n/31$). The bold line represents the mean difference between sessions 1 and 2 and the dotted lines the 95% limits of agreement.

Discussion

To our knowledge, this is the first study to investigate the validity, test–retest reliability and minimal detectable change of the BESTest, Mini-BESTest and the Brief-BESTest in patients with ESRD. The three tests are valid and reliable to assess balance in patients with ESRD. The preliminary MDC found for these balance tests can be used by clinicians to identify a true change in balance in patients with ESRD.

In this study, 37.8% of patients reported at least one fall in the previous 12 months. This result is in line with previous research [5,6]. In healthy older adults slightly lower prevalences have been described (12.1–33%) [27,36,37]. In addition, patients with history of falls were older than those without history of falls and had worse performance in balance tests. It is known that older adults frequently present reduced skeletal muscle strength, gait speed and physical activity levels [38]. These impairments may have also contributed to the balance deficits found in patients with ESRD. This finding highlights the need of screening for balance impairments in the comprehensive assessment of patients with ESRD, particularly in those with more advanced age.

The BESTest, Mini-BESTest and Brief-BESTest have shown to be valid in a variety of clinical populations [10,18,26,39]. In patients with ESRD, the three balance tests were also significantly associated with each other and with the ABC scale, demonstrating good concurrent and convergent validity.

Excellent results were found for test–retest reliability of the balance tests (ICC 0.84–0.94). Similar results have been found in reliability studies conducted in other populations, such as Parkinson's disease (ICC = 0.88–0.90) [13], older cancer survivors (ICC 0.90–0.94) [10], chronic obstructive pulmonary disease (ICC 0.82–0.87) [15] and stroke (ICC 0.97) [26]. Regarding agreement, results were also encouraging since balance tests showed good agreement, with no systematic bias. Thus, it seems that clinicians can be confident in using these three balance tests to assess balance impairments in patients with ESRD.

In this study, preliminary MDC₉₅ values for BESTest, Mini-BESTest and Brief-BESTest were determined, which will be useful for clinicians working with patients with ESRD in assessing whether an intervention (e.g., rehabilitation program) has caused any real change in balance. However, MDCs were slightly higher than those established in other populations: BESTest (10.8 vs. range 6.2–9 [10,15,40]), Mini-BESTest (5.3 vs. range 2.4–3.8 [10,15,18,40]) and Brief-BESTest (5.6 vs. range 2.6–4.9 [10,15,40]).

These differences may be explained by the specificities of each population. But may also be related with the samples used. In the present study, participants' mean age was 63.9 years old, with large age range 30–95. In the reported studies patients were somewhat older (mean ages between 66 and 76 years old [10,15,18,27,40]). It should be also noted that the MDC% of the Brief-BESTest was slightly higher (34%) than the value considered acceptable (i.e., <30%). However, this MDC% was obtained from one single performance at each session. Future studies should determine the MDC₉₅ and MDC% from the average of two performances at each session. This procedure may reduce the magnitude of measurement error and consequently achieve lower values for the MDC₉₅ and MDC%. This has been observed in tests for functional balance assessment, such as the timed up and go test [40].

There are limitations in the present study that need to be acknowledged. First, the small sample size. Yet, the number of patients included is within the range (28–122) used in previous research assessing the clinimetric properties of the BESTest, Mini-BESTest or of the Brief-BESTest [10,18,27,40]. Second, the sample was mainly composed of patients aged 60 or over (>70%), so generalization of findings are hindered to the younger population of patients with ESRD. Future studies may replicate the study in larger samples of younger patients and report results per age ranges. Third, patients were classified as having or not having a history of falls based on

their self-report hence, some degree of bias in their responses might have been present. Finally, the Mini- BESTest (14 tasks) and Brief- BESTest (6 tasks) scores were derived from the patients' performance on BESTest (36 tasks). The length of the BESTest may have produced a certain degree of fatigue. Thus, it might be thought that the scores of the BESTest shortened versions could be slightly different if performed independently from the BESTest. However, in order to address this concern, participants were given frequent resting breaks during the balance assessment. To clarify this, future studies should assess the validity, test–retest reliability and minimal detectable change of the Mini-BESTest and of the Brief-BESTest when performed separately from the BESTest.

The BESTest, Mini-BESTest and the Brief-BESTest are valid and reliable to comprehensively assess balance in patients with ESRD. Nevertheless, based on the minimal detectable changes, BESTest and Mini-BESTest may be the most recommended; and the selection of one of them may be based on time and equipment availability.

Disclosure statement

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